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Competition or collaboration? A comparison of health services in the UK

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Although devolution has had a major impact on the organisation of health services in the UK, there have always been differences between England, Scotland and Wales. Before the advent of the NHS in 1948 cooperative models of providing health services were more common, and more developed, in Wales than in England – indeed it has been suggested that Bevan's ideas on the NHS were based on his experiences with the Welsh miners' welfare system.[1] In England the voluntary hospitals, including teaching hospitals such as St Bartholomew's, St Thomas' and Sheffield Royal Infirmary, provided a considerable proportion of hospital care, alongside the local authority and community hospitals. Voluntary hospitals, supported by charitable donations, were far less common in Wales and Scotland than England.

Although the principles and basic structure were similar in the three countries when the NHS was introduced, differences remained. Until 1974, for example, teaching hospitals in Scotland were incorporated within the regional hospital boards in contrast to the independent boards of governors existing in England and Wales. When the three countries are compared differences in health status, and the underlying reasons for this, must be taken into account. Health in Scotland and Wales has always been worse than in England, associated with greater levels of deprivation. Infant mortality, often taken as an index of the health status of a country, demonstrates this (Table 1). Seventy years ago the rate was greater in Scotland than England and Wales. The differences have narrowed, now England has a higher rate than Wales or Scotland.

Since devolution, differences in priorities and structure have become more evident. Previously there were differences in emphasis – for example, fundholding, which became reasonably common in general practice in England for a time in the late 1980s and early 1990s, was less common in Wales and Scotland. All three countries were subjected to many organisational changes between 1989 and the present, but divergence has been much greater since devolution. In England there is a clear split between providers and commissioners with 152 primary care trusts, coterminous with local authorities, 168 acute and 73 mental health trusts responsible for the hospitals, and community health services. There are 10 strategic health authority outposts of the Department of Health, responsible for strategy and oversight. One hundred and twenty-two hospital trusts are foundation trusts with much greater financial and operational freedom and governed by boards made up partly of appointed members representing staff and management interests and partly members elected by patients. These foundation trusts are overseen by an independent quango, called Monitor, which is largely responsible for financial oversight.

Table 1. Infant mortality rates per 1,000 live births.

	1931–40	1971	1981	1991	2008
England	58	17.5	10.9	7.3	4.7
Wales		18.4	12.6	6.6	4.1
Scotland	76	19.9	11.3	7.1	4.2

In Scotland, since 2004, the NHS has been integrated. There are 14 geographically-based local NHS boards and a number of national special health boards. Trusts were abolished and hospitals are managed by the acute division of the NHS board. General practitioner, pharmacy, optician and related services are contracted through the NHS board but work in community health partnerships, based largely on local authority boundaries serving about 100,000 people. These boards include local authority representatives. It is proposed that legislation will be enacted to bring in direct elections to health boards.

Up to October 2009 there were 22 local health boards and seven NHS trusts in Wales. These have been replaced by seven local health boards responsible for all healthcare services. This opens the opportunity for a truly integrated health system. Further work is underway to ensure local integration too with social services provision. A new unified public health organisation, Public Health Wales NHS Trust, Velindre NHS Trust, the specialist Cancer Trust and the Welsh Ambulance Services NHS Trust also became operational. These have an appointed authority, including local authority representatives.[2] The aim in both Scotland and Wales is stated to be to remove bureaucracy, improve health outcomes, improve collaborative working and focus on public health, 'creating a wellness service, rather than a sickness service'.

These differences in structure of health services in the three countries are a manifestation of major differences in the attitudes of their population and politicians. Private practice has always been much less common in Scotland and Wales than England, which has meant that 'contracting out', for example, to independent treatment centres, is rare or absent. Public health, and its component parts, has always had a more powerful voice and influence in both universities and the NHS. *The Herald*, for instance, publishes a four-page insert from Glasgow's director of

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public health twice a year. Klein[3] considers that 'while in the English NHS relations between policymakers and professionals have become more antagonistic over the decades, the same does not seem to apply in the smaller UK countries'. He also states that 'the English NHS is remarkable for the explosion of value statements produced by its component organisations'. Kerr and Feeley[4] consider that the Scottish view of the NHS is collaboration and collectivism and has not adopted many of the aspects of a 'market-based relationship'. While England is developing a 'bill of rights' for patients, Scotland is developing 'mutuality', emphasising that while both patients and staff have rights, they also have responsibilities to collaborate in improving health. A membership organisation, Cooperation and Mutuality Scotland (CMS), has been created to 'meet their common economic, social and cultural needs and aspirations'.[5] This is also true for Wales,[6] which, even under tremendous pressure from London, has always rejected the option of establishing foundation hospital trusts and the use of the private sector. The Welsh minister for health and social services has an independent 'Bevan Commission' to ensure that the founding principles are followed. Wales has also retained such committees as the Welsh Medical Committee with access to ministers. Two other specific examples of differences are the abolition of the prescription charge in Wales and the payment for community social care in Scotland.

Greer,[7] in his analysis of the differences, states that English policymakers, in contrast to the devolved countries, focus 'on ends more than means, and policy debate is about fitting means to ends'. In the other two countries there is more emphasis on 'communitarianism and local participation as means and ends'. Both Wales and Scotland have neglected 'contestability and competition – keywords of English policy'. Thus, we have two models for the provision of health services – one with a predominant ethos of the market and competition, the other with coordination, collaboration and local participation as its major drivers.

Given that the education, training and standards of those providing health services, as well as the methods and means of delivery are similar, it is important to look at measures of outcome of the NHS in the three countries. Comparisons are difficult as there have always been quite large differences in such measures as mortality, both total and cause specific, and morbidity, whether measured as hospital episodes, sickness absence or GP utilisation. There are also differences in the causes of ill-health (both past and present): these include hazardous occupations such as coal mining, environmental causes such as levels of air pollution, behavioural factors such as smoking, and above all levels of poverty. In making rational comparisons, factors such as density of population (and urbanisation), difficulties in communication in remote and rural areas, and age/sex composition of the population must also be taken into account.

Life expectancy at birth, for males changed more in England (5.3%) than Scotland (4.6%) or Wales (4.8%) between 1991–3 to 2005–7. There was no difference for females between England and Scotland (3.4%) but less for Wales (2.9%). Rates of change for cancer mortality between 1993 and 2005 were almost the same in all three countries. Mortality for ischaemic heart disease in men between 1999 and 2006 diminished by 33.5% in England, 36.2% in Scotland and 35% in Wales; in women it diminished by 33.2% in England, 33.3% in Scotland and 29.6% in Wales.

There are some differences in health service process measures – for example, the median waiting time for angiography in 2006–7 in England was 56 days, in Scotland 35 days and in Wales 67 days. Median waiting for hip replacement in 2006–7 in England was 151 days, in Scotland 122 days and Wales 221 days. The average number of admissions treated per available bed in 2005–6 in England was 49, Scotland 49 and Wales 36. Overall perceptions of the quality of care were similar although the Scots were more likely to rate it as excellent.[8]

There are differences in the attitudes, behaviour and beliefs of the populations of the UK which have been addressed briefly above. Most of these have been present for a very long time. Devolution has enabled Wales and Scotland to pursue somewhat different paths to England. It is difficult to conclude that the market model with a strong regime of targets and 'naming and shaming' in England delivers better and more effective healthcare, as suggested by a recent Nuffield Trust report,[9] than the more 'communitarian' policies of Wales and Scotland. For some indicators Wales is worse off than England, but for others Scotland has better results than England. The difficulty in all comparisons and in the assessments made is that there has been an improvement in almost all measures in the past 10 years in all three countries. But it must be remembered that health, environmental and social conditions were not, and are not, the same in the three countries. In the long term, the emphasis in Wales and Scotland on public health policies and communitarian cooperation may, if continued, be more effective in improving health than the emphasis on markets, competition and choice. Wales and Scotland consider the relationship between the patient/citizen to their national public service an important factor – as opposed to choice judgements on access times.

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EDITORIALS

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Specialty certificate examination in gastroenterology

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The aim of training in medicine is to create future consultants with the knowledge, skills and attributes required to provide high quality care to patients. Several recent pressures have resulted in changes to medical training. As a consequence, assessment has become more important with the need to test both the knowledge base and workplace skills to ensure that trainees are ready to face the complexity of demands they will meet as a new consultant.

The medical royal colleges and specialist societies have taken a lead in providing guidance on how to improve training and assessment. The need to ensure that trainees have the knowledge to practise safely is vital. MRCP(UK) has provided a successful platform for launching trainees who have a good fundamental core of knowledge and skills in general medicine that allows them thereafter to diversify into various medical specialties. The MRCP(UK) skill base has now led to the development of specialty certificate examinations (SCEs) in a range of medical specialties (www.mrcpuk.org/SCE/Pages/Home.aspx). MRCP(UK) has over many years developed assessments that reflect the range of experience required of trainees (validity), are reproducible (reliability) and are set at the required standard.

Gastroenterology is a rapidly developing medical specialty with a large body of knowledge, much of which is recent, and many and varied sources of national and international guidelines giving advice on ideal management. The training curriculum has recently been completely revised after significant consultation. It is also a very demanding service specialty with large outpatient clinics, busy endoscopy services, multidisciplinary teams, subspecialty development and for most a continued commitment to acute general medical receiving. Daily work requires good communication skills, diagnostic acumen, manual dexterity, ability to assess complex images and the need to work as part of a team. Assessment has to reflect this complex interaction of skills. Gastroenterology is a visual specialty that requires the regular interpretation of endoscopic, radiologic and histological images in relation to the individual patient's problem.

Colleges have followed best educational advice as to how to assess such complex clinical skills. MRCP(UK) has developed the 'best of five' format question to test real clinical scenarios and offer five feasible alternative answers to a diagnostic, investigation or management problem. One option is always agreed to be the most correct. This format reflects the clinical dilemmas and options available in practice. The full curriculum is tested by following a blueprint that ensures that a fixed proportion of all subjects are selected for each diet of the examination. The reliability of the examination is ensured by providing sufficient questions (200) to make certain that the assessment would give reproducible results in each cohort of candidates. The standard for each diet is set in advance by a standard setting group who consider the complexity of each individual question and award it a mark, which then contributes to an overall criterion referenced pass mark for that diet.

The SCE in gastroenterology has therefore been developed to allow fair and accurate assessment of trainees' abilities to assess and respond to clinical problems. It is currently held once per annum and is computer based with two three-hour papers containing 100 questions each. The computer-based testing allows many venues to hold the SCE simultaneously throughout the UK and internationally. The SCE is designed for UK specialist trainees but overseas candidates who hold MRCP(UK) and have relevant training can also apply. UK trainees who commence training from August 2007 onwards will be required to pass the SCE in order to be awarded a Certificate of Completion of

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